

**To**

Public Health Clinic Services  
925-313-6250 **(phone)**  
925-313-6029 **(fax)**

\*\*\*Please attach all  
pertinent medical records  
and patient registration with  
current demographics.

If requesting feedback,  
please include phone  
number to call.

*Due to limited resources, all clients  
may not be served.*



PLACE REGISTRATION STICKER HERE

**Public Health Nurse Referral Form**

(For Clinic Referrals only)

Date of Referral: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Client Name: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Medical Record#: \_\_\_\_\_

**PLEASE ATTACH PATIENT REGISTRATION SHEET (FACE-SHEET)  
AND PERTINENT CLINIC NOTES**

Demographic information (if different than patient registration):

Address: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Preferred Language: ☐ English ☐ Spanish ☐ Other \_\_\_\_\_

**Reason for Referral:**

- ☐ Postpartum at risk (lactation issues, teen, social issues)  
☐ Newborn at risk  
(wt loss 8- 10%, SGA, medical issues, feeding issue, < 36wks gest)  
☐ Perinatal Depression (mod/severe)

Child at risk/needs linkage to:

- ☐ Specialty Care ☐ Developmental Services  
☐ Mental Health ☐ School District  
☐ Other: \_\_\_\_\_

Brief Description of the reason for referral:

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**Disposition:**

- ☐ Unable to contact/locate ☐ Assigned to PHN  
☐ Does not meet criteria for services ☐ Unable to provide services

Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Program: \_\_\_\_\_

☐ Feedback requested To: \_\_\_\_\_ Phone: \_\_\_\_\_